MEDICAL ETHICS

The medical ethics of Dr J Marion Sims: a fresh look at the historical record

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Vesicovaginal fistula was a catastrophic complication of childbirth among 19th century American women. The first consistently successful operation for this condition was developed by Dr J Marion Sims, an Alabama surgeon who carried out a series of experimental operations on black slave women between 1845 and 1849. Numerous modern authors have attacked Sims's medical ethics, arguing that he manipulated the institution of slavery to perform ethically unacceptable human experiments on powerless, unconsenting women. This article reviews these allegations using primary historical source material and concludes that the charges that have been made against Sims are largely without merit. Sims's modern critics have discounted the enormous suffering experienced by fistula victims, have ignored the controversies that surrounded the introduction of anaesthesia into surgical practice in the middle of the 19th century, and have consistently misrepresented the historical record in their attacks on Sims. Although enslaved African American women certainly represented a ''vulnerable population'' in the 19th century American South, the evidence suggests that Sims's original patients were willing participants in his surgical attempts to cure their affliction—a condition for which no other viable therapy existed at that time.

J Marion Sims (1813–1883) was arguably the most famous American surgeon of the 19th century and today he is generally acknowledged as the founder of modern surgical gynaecology. His rise to prominence began with his development of the first consistently successful operation for the cure of vesicovaginal fistula, a catastrophic complication of childbirth in which a hole develops between a woman's bladder and her vagina and leads to constant, unremitting, and uncontrollable urinary incontinence. Attempts to cure this condition had eluded many previous generations of surgeons who had tried to repair these devastating injuries time and again, but without significant success.[1]

Lauded as a conquering surgical hero in his own time and generally admired by succeeding surgeons in the decades following his death,[2] Sims's reputation diminished considerably in the mid-twentieth century as it was assaulted by a series of strident critics who condemned him for his reputedly unethical behaviour.[3–9] The primary reason for these attacks on Sims is that his initial attempts to cure vesicovaginal fistulas were carried out on a group of enslaved African American women whom he quartered in a small hospital behind his house in Montgomery, Alabama. Between late 1845 and the summer of 1849, he carried out repeated operations on these women in a dogged effort to repair their injuries. One young woman, a slave named Anarcha with a particularly difficult combination vesicovaginal and rectovaginal fistula, underwent 30 operations before Sims was able to close the holes in her bladder and rectum.

In interpreting these historical events, some modern writers have denounced Sims with the kind of righteous indignation that is usually heard only from pulpits. Durrenda Ojanuga—for example, writing in the *Journal of Medical Ethics*—has castigated Sims for achieving fame and fortune as ''a result of unethical experimentation with powerless Black women'' and refers to his attempts to cure vesicovaginal fistulas as ''a classic example of the evils of slavery and the misuse of human subjects for medical research''.[9] Ojanuga and like minded critics present a picture of Sims as a cold, brutal, calculating misogynist who carried out a series of unwarranted surgical experiments on unwilling but helpless slaves in pursuit of his own self advancement. This paper will demonstrate that the attacks launched against Sims by these modern writers are actually not substantiated by the primary historical sources relating to the case, nor are their charges consistent with any deep clinical understanding of the predicament faced by women who have developed a vesicovaginal fistula from obstructed labour; rather, their analysis of Sims's early surgical operations on vesicovaginal fistulas can be seen as a striking example of Herbert Butterfield's observation that ''for the compilation of trenchant history there is nothing like being content with half the truth''.[10]

Distilled to their essential points, Sims's modern critics make three major claims about Sims and his early operations for vesicovaginal fistula. The first assertion is that it was unethical ''by any standard'' to perform experimental surgical operations on slaves because slaves, by definition, could not have given voluntary informed consent for surgery.[9] Underlying this assertion is the hidden presupposition that enslaved women with fistulas did not want surgical care for their condition (vesicovaginal fistula) and that they were therefore coerced into having unwanted (and perhaps, unnecessary, surgery). The second assertion is that Sims's failure to use ether anaesthesia during these

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operations was racist: that he did not use anaesthesia when performing fistula surgery on black women, but later, after he had developed his operation and moved to New York to found the Woman's Hospital there, he routinely used anaesthetics when operating on white women who, it is alleged, unlike blacks, were unable to stand the pain involved.[4–8] The third assertion is that the use of slaves for medical experimentation was unnecessary because substantial advances in medical care were made in the 19th century by Southern physicians who experimented in an ethical manner using white women from whom they obtained ''informed consent'', a circumstance that modern critics assert did not exist with regard to Sims's operations on these early slave women.[9] Close examination of primary source material demonstrates that each of these claims about Sims is either unsubstantiated or demonstrably false. The inevitable conclusion seems to be that the accusations levied against Sims by modern authors are largely the result of the unquestioned presuppositions that these authors have made regarding the clinical problem Sims and his first patients faced; shoddy historical research, and an abysmal lack of understanding of the future life prospects faced by a woman who had a vesicovaginal fistula in 1845.

What is a vesicovaginal fistula and how does it originate? Obstetric vesicovaginal fistulas do not arise, as many authors commonly state, as the result of ''tears'' to the bladder during labour; rather, they are the result of a massive crush injury to the soft tissues of the pelvis.[11 12] Obstetric vesicovaginal fistulas develop during prolonged obstructed labour when the fetus will not fit through its mother's birth canal. In the presence of absolute cephalopelvic disproportion, the contracting uterus tries to force the fetus through the birth canal but only succeeds in gradually wedging the fetus more and more tightly into the maternal pelvis until eventually it can no longer be moved at all. At this point, the soft tissues of the woman's bladder, cervix, and vagina are trapped progressively more and more tightly between two immovable bony plates—the fetal skull and the mother's pelvic bones—and the blood supply to the entrapped tissues is shut off. In such cases the fetus almost invariably dies from asphyxiation, and if the mother lives through her ordeal and does not herself die from uterine rupture, sepsis, haemorrhage, or the sheer exhaustion of labouring in this fashion for days on end, a day or two later the fetus decays, macerates, and finally softens enough to slide out of its mother's vagina. Some time thereafter, a slough of necrotic tissue comes away from the injured woman's vesicovaginal septum, and a fistula forms. To the agony of days of unrelieved labour and the sorrow of delivering a dead child is now added the physical and social calamity of complete loss of urinary (and often faecal) control.[11–13]

The injuries that women receive from prolonged obstructed labour are not limited to vesicovaginal and rectovaginal fistulas. These injuries form only a small part of a broader spectrum of injuries known as the ''obstructed labour injury complex''.[11 14] In addition to the continuous stream of urine (and sometimes faeces) to which they are subjected, these victims of prolonged obstructed labour also often suffer from secondary infertility; loss of vaginal function due to extensive scarring of the birth canal; damage to the pubic bones; contractures of the lower extremities from neuromuscular damage; recurring pelvic and urinary tract infections; horribly diminished self esteem, damaged body image, and, not infrequently, severe depression, even suicide. The cumulative devastation wrought by this process can be appalling. It is hardly the ''relatively minor condition'' referred to by historian Deborah Kuhn McGregor.[6]

In alleging that it is unethical for slaves to participate in any form of medical experimentation, Ojanuga and other writers seem to imply that it would never have been appropriate for slaves to undergo innovative surgical operations, no matter what their problems might have been. Critics of this stripe conveniently ignore the differences between non-therapeutic and therapeutic medical experimentation. In the former case, participants can have no reasonable expectation of obtaining direct personal benefit from whatever is done, but in the case of therapeutic experimentation research participants may gain direct—and sometimes substantial—medical relief as a result of their participation in a clinical trial. At the time Sims began his attempts to repair the fistulas afflicting his African American slave patients, there was no effective therapy for a vesicovaginal fistula. Many surgeons in different countries had made repeated but unsuccessful attempts to close vesicovaginal fistulas and put an end to the tormenting loss of urine that these suffering women experienced. With rare exceptions, all such attempts failed. The French surgeon Alfred Velpeau, writing in 1847, maintained that the medical community had not accepted a single reported case of successful cure of a vesicovaginal fistula without dispute.[15] The common experience of surgeons who undertook the care of women with vesicovaginal fistulas was a repeated series of failures, with the desperate patients returning again and again, begging that another attempt be made to give them some relief.[1 16 17]

Because Sims's patients had a condition that was generally acknowledged to be incurable, they had only two therapeutic choices: they could continue as they were, with whatever palliative treatment might be provided, or they could agree to undergo experimental surgical operations that might offer them some relief, perhaps even a total cure, for their condition. What would the first alternative have been like? What ''palliative treatments'' were available to fistula sufferers at this time? Is it true, as Diane Axelson has charged, that both Sims and his subsequent biographer, Seale Harris, portrayed the physical condition of women with fistulas with ''unjustified exaggeration''?[5] Is it reasonable to suppose, as Patricia King has speculated, that ''given the other aspects of slave life, it is not clear that these women would have ranked this problem high on their list of medical problems that needed attention''?[18] Consider the following description of what it was like to be a woman with a vesicovaginal fistula in the mid-19th century, given by Dr P M Kollock at the annual meeting of the Georgia State Medical Society in April, 1857:

> The poor woman [with a vesicovaginal fistula] is now reduced to a condition of the most piteous description, compared with which, most of the other physical evils of life sink into utter insignificance. The urine passing into the vagina as soon as it is secreted, inflames and excoriates its mucous lining, covering it with calcareous depositions, and causing great suffering. It trickles constantly down her thighs, irritates the integument with its acrid qualities, keeps her clothing constantly soaked, and exhales without cessation its peculiar odour, insupportable to herself and those all around her. In cases where the sloughing has been extensive, and the loss of substance of the tissues great, and where neither palliative nor curable means have availed for the relief of the sufferer, she has been compelled to sit constantly on a chair, or stool, with a hole in the seat, through which the urine descends into a vessel beneath.[19]

Given the choice between living the rest of their lives in this manner or of taking a chance—however remote—that Sims might be able to cure them, it is not surprising that these patients, even though they were enslaved, would have

jumped at the opportunity to have surgery. That patients with a vesicovaginal fistula are desperate for a cure and will willingly submit to almost any therapy that is proposed to them is the universal experience of surgeons who have worked with this condition, both in the 19th century and today.[12 13 20]

In her article, which is critical of Sims, Durrenda Ojanuga states that: ''The enslaved women were not asked if they would agree to such an operation as they were totally without any claims to decision making about their bodies or any other aspect of their lives''.[9] This statement is untrue. Sims gave numerous accounts of these early fistula operations during the course of his career, and, although they differ in some details, they all state quite plainly that he discussed what he proposed to do and obtained consent from the patients themselves before undertaking any operations. Writing in the *New York Medical Gazette and Journal of Health* in January, 1855—for example, Sims declared:

> For this purpose [therapeutic surgical experimentation] I was fortunate in having three young healthy colored girls given to me by their owners in Alabama, I agreeing to perform no operation without the full consent of the patients, and never to perform any that would, in my judgment, jeopard life, or produce greater mischief on the injured organs—the owners agreeing to let me keep them (at my own expense) till I was thoroughly convinced whether the affection could be cured or not.[21]

It is true that under Southern law, slaves were the property of others and Sims could not have legally operated on them without the consent on their owners; however, this cannot be taken as a priori proof that these slaves were unwilling patients. As a matter of surgical practicality, considering the delicate and tedious requirements of performing surgery inside the vagina and the exceedingly difficult circumstances of exposure and inadequate lighting under which he was forced to operate, Sims could not have carried out these operations successfully without the cooperation of the women involved. Even the slightest movement, much less the active resistance of these patients, would have rendered it impossible for him to have completed his operative procedures. Indeed, when his regular medical assistants tired of working with him, Sims trained the patients themselves to act as his surgical assistants and they thereafter helped him operate on one another in turn! In fact, in a passage in his autobiography that his modern critics have apparently not understood, Sims wrote that at a time when he had stopped attempting surgery on these women due to his repeated failures and was wondering how best to proceed, they ''clamoured'' for operations, insisting that he keep trying to cure their injuries. No wonder he owed these women a debt of gratitude for their persistence and their cooperation—a debt that he readily acknowledged publicly on numerous occasions.[1 21–23]

Why did Sims not use anaesthesia when carrying out these operations? Was he an ''anaesthetic racist,'' as has some authors allege? Vanessa Northington Gamble—for example, maintains that, in contrast to the way he treated slaves, Sims only operated on white women using anaesthesia.[4] The chronology of events is extremely important here. Sims grew up as a surgeon in the days before anaesthetics and was accustomed, as were all of his contemporaries, to the pitfalls and requirements of preanaesthetic surgery. Durrenda Ojanuga writes: ''He performed his first operation on a slave woman named Lucy. Lucy was operated on without anaesthetics as Sims was unaware of the advances which had been made in this area of medicine.''[9] This statement is not true. Sims began his fistula operations on his enslaved patients in late 1845, *before* the anaesthetic properties of ether were known. Ether anaesthesia was not discovered and publicly demonstrated in Boston until October 16, 1846, nearly one year later.[24] Although the use of anaesthesia spread rapidly, its acceptance was not universal, and there was considerable opposition to its introduction from many different quarters, for many different reasons. As historian Martin Pernick has written:

> Our twentieth century sensibilities recoil at the thought that sane, responsible physicians could ever have opposed the use of anaesthetics. Today, the concept of operating on a fully sentient patient conjures up only hellish images of concentration camp doctors. Yet in mid-nineteenth century America, humane, conscientious, highly reputable practitioners and ordinary lay people held many misgivings about the new discovery. Neither sadists nor fools, these critics alleged a variety of rational drawbacks to the use of anaesthesia.[25]

Many 19th century surgeons felt that attempts at repairing vesicovaginal fistulas were neither serious nor painful enough operations to warrant the risks of general anaesthesia. Sir James Young Simpson, the discoverer of chloroform and probably the most vigorous advocate of the use of anaesthesia on women during the 19th century, was one of these people. Writing about the use of anaesthesia during fistula surgery in 1859, a full decade after Sims's initial surgical experiments had been completed, this champion of anaesthesia could declare that chloroform was not absolutely necessary in the performance of fistula operations, since ''The mere amount of pain endured by the patient is perhaps less than in most surgical operations, as the walls of the vesicovaginal septum are far less sensitive than you would a priori imagine''.[26]

Ojanuga further states that: ''Many white women came to Sims for treatment of vesicovaginal fistula after the successful operation on Anarcha. However, none of them, due to the pain, were able to endure a single operation.'' This allegation, often repeated, is also false. For example, Sims published a detailed case study of a white woman who came to him with a fistula in 1849, which he was eventually able to repair after three operations, none of which involved the use of anaesthesia.[27] Terri Kapsalis, writing with reference to Sims's later career in New York, declares that ''the widespread use of anesthetics finally allowed Sims to bring his surgeries to white women and allowed for the establishment of places such as the Woman's Hospital''.[8] Sims himself, however, in a public lecture to the New York Academy of Medicine given on November 18, 1857, at a time when he was actively engaged in the practice of surgery at the Woman's Hospital in New York (whose clientele were almost exclusively white and many of whom were of middle or upper middle class origin), noted that he *never* resorted to the use of anaesthetics in fistula operations ''because they are not painful enough to justify the trouble, and risk attending their administration''.[22] In retrospect this was certainly an unfortunate error in clinical judgment—a mistaken ''calculus of suffering''—but it was not anaesthetic racism. It is also worth pointing out that if Sims had used anaesthesia in operating on his first fistula patients before the safety and efficacy of ether and chloroform had been sufficiently established for routine clinical use, this, too, would have constituted another therapeutic experiment on slaves.

In her final assault against Sims, Durrenda Ojanuga maintains that significant medical breakthroughs were achieved in the antebellum South without using slaves in

therapeutic experiments. To buttress her argument, she compares Sims unfavourably with Dr Ephraim McDowell (1771–1830) of Danville, Kentucky, and with Dr Crawford W Long (1815–1878) of Georgia. McDowell was the first surgeon to successfully open the peritoneal cavity and carry out a major intra-abdominal operation. With her consent, McDowell removed a 22 pound benign ovarian tumour from Jane Todd Crawford, a white woman, on December 13, 1809, without anaesthesia, carrying out the operation on a kitchen table. She recovered completely and survived to a ripe old age. Crawford Long was a Georgia dentist who noticed the intoxicating effects of sulfuric ether that the youth of his community were using as a recreational drug during periodic ''ether frolics''. He decided to try ether as an anaesthetic agent during surgical operations. In 1842 he successfully removed a small tumour from the neck of James Venable, a white man, who had given his consent to the procedure.

These examples are true as far as they go, but both accounts given by Ojanuga selectively omit major pieces of information that, once known, completely deflate the case she is attempting to make against Sims. Although it is true that McDowell performed his first ovariotomy on Jane Todd Crawford, a white woman, Ojanuga neglects to inform her readers that McDowell performed this operation at least seven more times during his lifetime and that four of these patients were black slave women, one of who died from complications.[28] With respect to Crawford Long, Ojanuga omits to mention the fact that he also used ether anaesthesia in a number of other surgical experiments in addition to the initial operation he performed on James Venable. For example, Long wrote the following in his article on the anaesthetic use of ether in the *Southern Medical and Surgical Journal* of December, 1849:

> Surgical operations are not of frequent occurrence in a country practice, and especially in the practice of a young physician; yet I was fortunate enough to meet with two cases in which I could satisfactorily test the anaesthetic power of ether. From one of these patients I removed three tumours the same day: the inhalation of ether was used only in the second operation, and was effectual in preventing pain, while the patient suffered severely from the extirpation of the other tumours. In the other case, I amputated two fingers of a negro boy: the boy was etherized during one amputation, and not during the other; he suffered from one operation, and was insensible during the other.[29]

Both free whites and enslaved blacks were involved in all of these experimental surgical operations. McDowell's operations were clearly performed with therapeutic intent, although it is unclear to what extent some of these black patients consented to surgery. If one assumes that the amputations performed by Long were clinically indicated, then he was performing necessary surgery while conducting a rather brutal (and probably unnecessary) comparative trial of the effects of ether on surgical pain.

CONCLUSION

It is difficult to make fair assessments of the medical ethics of past practitioners from a distant vantage point in a society that has moved in a different direction, developed different values, and has wrestled—often unsuccessfully—with ethical issues of sex, race, gender, and class that were not perceived as problematic by those who lived during an earlier period of history. J Marion Sims was a dedicated and conscientious physician who lived and worked in a slaveholding society. As such, he was often called upon to care for slaves with legitimate medical needs. Among the needs that many 19th century women faced—both white and black—was the need for treatment of catastrophic complications of childbirth such as vesicovaginal fistulas. The operations carried out by Sims on black slave women from 1845–1849 represented his attempt to cure them of an odious and devastating condition that was then considered incurable. His operations, which at first were unsuccessful, were performed explicitly for therapeutic purposes and, as far as we can tell from the surviving sources, were carried out with the patients' cooperation and consent. At the time Sims began his efforts to close vesicovaginal fistulas, there was no effective alternative to surgical treatment and the quality of life to which such patients were reduced by their injuries was acknowledged by all medical writers of the time as unendurable. There is no doubt that slaves in the mid-19th century American South were a ''vulnerable'' population who were often subjected to significant abuse by the slaveholding system. To suggest, however, that for that reason alone no attempts should have been made to cure the maladies of such enslaved women, especially when they were desperate for help and no other viable alternatives existed, seems ethically bankrupt itself. Whatever his other failings may have been, J Marion Sims pursued this clinical goal with vigour, determination, and perseverance, and both his patients then and countless thousands of women since, benefited from his success.

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